

<b>Case Number:</b>	CM14-0097267		
<b>Date Assigned:</b>	07/28/2014	<b>Date of Injury:</b>	04/07/2004
<b>Decision Date:</b>	01/05/2015	<b>UR Denial Date:</b>	06/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/25/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Family Medicine, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 55-year-old male who experienced an industrial injury on 04/07/04. The mechanism of injury and the body part(s) involved were not addressed in the documentation. There are numerous office visit evaluation reports available for review on dates of service, 03/04/14, 04/02/14, 06/03/14, 07/30/14, and 08/27/14. The subjective and objective findings were very similar in nature. The worker sought treatment for his complaints of persistent pain C-L/S into bilateral upper and lower extremities and recent increase in the symptoms of the left shoulder. Objective findings noted an L/S MRI performed 07/12/13 with results revealing L4-5 spondylolisthesis with disc bulge, degenerative disc disease and foraminal stenosis. There was tenderness to palpation, spasm, and decreased range of motion to the lumbosacral area. The left shoulder was noted to have +imp symptoms and decreased range of motion. Diagnosis was displacement intervertebral disc site uns w/o myelopathy (ICD-722.2) (ICD10-M53.80). He was given an injection to the left shoulder subacromial space at this office visit. Treatment recommendations included continued pain management and psych.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Oxycodone 30 mg tablets, #120 with no refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 81-82, Chronic Pain Treatment Guidelines Part 2 - Pain Interventions and Treatments Page(s): 74-75, 83-84, 87, 92, 97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Appendix A, ODG Workers' Compensation Drug Formulary, Oxycodone 30 mg, per ODG website

**Decision rationale:** Guidelines note that opiates are indicated for moderate to moderately severe pain. Opioid medications are not intended for long term use. As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on opiates long term. However, the medical records do not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. MTUS Guidelines require clear and concise documentation for ongoing management. Therefore, the request is not reasonable to continue. Additionally, within the medical information available for review, there was no documentation that the prescriptions were from a single practitioner and were taken as directed and that the lowest possible dose was being used. Therefore, this request is not medically necessary.

**Zohydro ER 30 mg capsules #60 with no refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Appendix A, ODG Workers' Compensation Drug Formulary, Zohydro ER 30 mg, per ODG website

**Decision rationale:** Guidelines note that opiates are indicated for moderate to moderately severe pain. Opioid medications are not intended for long term use. As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on opiates long term. However, the medical records do not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. MTUS Guidelines require clear and concise documentation for ongoing management. Therefore, the request is not reasonable to continue. Additionally, within the medical information available for review, there was no documentation that the prescriptions were from a single practitioner and were taken as directed and that the lowest possible dose was being used. Therefore, this request is not medically necessary.